STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	N046057	A. BUILDING _____ B. WING _____	C 03/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ABERDEEN VILLAGE	17500 WEST 119TH STREET OLATHE, KS 66061

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS The following citations represent the findings of complaint investigation #KS 55311.	S 000		
S3028 SS=D	26-41-101 (f) (3) Staff Treatment of Residents Reporting (f) (3) Each allegation of abuse, neglect, or exploitation shall be reported to the administrator or operator of the facility as soon as staff is aware of the allegation and to the department within 24 hours. The administrator or operator shall ensure that all of the following requirements are met: (A) An investigation shall be started when the administrator or operator, or the designee, receives notification of an alleged violation. (B) Immediate measures shall be taken to prevent further potential abuse, neglect, or exploitation while the investigation is in progress. (C) Each alleged violation shall be thoroughly investigated within five working days of the initial report. Results of the investigation shall be reported to the administrator or operator. (D) Appropriate corrective action shall be taken if the alleged violation is verified. (E) The department ' s complaint investigation report shall be completed and submitted to the department within five working days of the initial report. (F) A written record shall be maintained of each investigation of reported abuse, neglect, or exploitation. This REQUIREMENT is not met as evidenced by: KAR 26-41-102(f)(3)(c)	S3028		

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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S3028	Continued From page 1 The facility identified a census of 39 resident. the sample included 3 residents. Based on observation, interview and record review, the facility failed to report and investigate unwitnessed falls which resulted in injuries for 1 of 3 residents sampled. (#1) Findings included: - Resident #1's Physician Order Sheet (POS) dated 6/30/11 listed aftercare following surgery of musculoskeletal system, personal history of fall, difficulty walking, osteoporosis, muscle weakness, urinary tract infection, essential hypertension, diabetes mellitus type 2, hypothyroidism, anemia, depressive disorder, hyperlipidemia and symbolic dysfunction. The Functional Capacity Screen dated 7/29/11 recorded the resident required physical assistance with bathing, was usually continent, had impaired cognition, short term memory problems, and memory recall problems, usually understood other's verbal communication, had falls and unsteadiness and used a walker. The Level of Care/Assistance Plan Form dated 7/29/11 recorded the resident was independent for dressing, transfer, walking, continence and toileting, personal hygiene tasks, and the resident had difficulty with recall requiring staff monitoring 1-2 times per shift. The Negotiated Services Agreement (NSA) dated 7/29/11 recorded staff provided the resident's fall prevention and pendant alarm, administered medications, managed the resident's diabetes, provided education, bathing, provided cues and reminders for activities and meals, provided personal laundry service, daily bed making, weekly cleaning and linens and social transportation. The Assisted Living Health Care Service Plan (care plan) dated 7/18/11 directed staff to cue the	S3028		

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S3028	Continued From page 2 resident for meals and activities, do weekly laundry, provide bathing assistance weekly and monitor the resident every 1-2 hours because the resident was a fall risk. The fall report dated 7/31/11 at 8:42 P.M. recorded the resident called for assistance, and staff found the resident on the floor in the bathroom with his/her top half of body on the shower floor and the bottom half of body on the bathroom floor with the resident's head under the wooden bench board. Staff identified a 3 inch abrasion on the resident' right lower rib cage, and assisted the resident into bed. The resident then screamed in pain and complained of pain when staff did Range of Motion (ROM) on the resident's right leg. The nurse's note dated 7/31/11 documented the resident fell again at 9:35 P.M. and staff sent the resident to the hospital's Emergency Room (ER). The hospital chest x-ray report dated 8/1/11 recorded, "Right rib series with chest x-ray. Right rib injury and pain....There is a non-acute fracture of the left 8th rib. There is an old fracture of what is likely the lateral aspect of the right 9th rib. No acute displaced rib fracture is identified." (A non-acute fracture is either one that occurs over time with repeated stress or impact of the area, or a chronically non=healing fracture.) The fall report dated 8/6/11 at 10:30 A.M. recorded staff found the resident sitting on the floor with his/her knees bent up, and the resident was very confused. The fall follow-up dated 8/10/11 recorded the resident was not aware when he/she fell. The nurse's note dated 8/6/11 at 11:30 A.M.	S3028		

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S3028	Continued From page 3 recorded the resident was very lethargic and responding briefly to stimuli, and staff sent the resident to the hospital's ER. The hospital ER note dated 8/6/11 recorded the resident admitted to the hospital's Intensive Care Unit (ICU) with a cerebral hemorrhage. Following the resident's hospital stay, the resident admitted to the facility's skilled nursing unit on 8/8/11 with a diagnosis of subarachnoid hemorrhage, (bleeding in the area between the brain and the thin tissues that cover the brain.) The hospital discharge summary dated 8/8/11 recorded, "Acute mental status change, secondary to left frontal subarachnoid hemorrhage, likely secondary to recurrent falling." The facility provided the policy entitled Abuse Prevention, Intervention, Reporting and Investigation - Staff Treatment of Residents - Zero Tolerance Policy dated 8/09 which directed, "It is the responsibility of employees to promptly report to community management any occurrence or suspected occurrence of neglect or resident abuse from other resident, staff, family or visitors, including injuries of an unknown source...The executive director or designee in conjunction with the health services director or designee, notifies the following of a suspected abuse occurrence: state licensing/certification agency within 24 hours..." During an interview on 3/20/12 at 12:49 P.M., administrative staff L stated the facility did not report the incidents dated 7/31/11 and 8/6/11 to the state reporting agency as an injury of unknown cause because he/she did not know the resident had injuries.	S3028		

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S3028	Continued From page 4 The facility failed to report and investigate 2 unwitnessed falls which resulted in injuries for this cognitively impaired dependent resident.	S3028		
S3155 SS=G	26-41-204 (a) Health Care Services . (a) The administrator or operator in each assisted living facility or residential health care facility shall ensure that a licensed nurse provides or coordinates the provision of necessary health care services that meet the needs of each resident and are in accordance with the functional capacity screening and the negotiated service agreement. This REQUIREMENT is not met as evidenced by: KAR 26-41-204(a) The facility identified a census of 39 residents. The sample included 3 residents. Based on observation, interview and record review, the facility failed to provide and apply effective safety interventions and adequate supervision for 2 of 3 residents sampled with a history of falls. (#1, #2) Findings included: - Resident #1's Physician Order Sheet (POS) dated 6/30/11 listed aftercare following surgery of musculoskeletal system, personal history of fall, difficulty walking, osteoporosis, muscle weakness, urinary tract infection, essential hypertension, diabetes mellitus type 2, hypothyroidism, anemia, depressive disorder, hyperlipidemia and symbolic dysfunction. The Functional Capacity Screen dated 7/29/11 recorded the resident required physical assistance with bathing, was usually continent, had impaired cognition, short term memory	S3155		

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S3155	Continued From page 5	S3155		

problems, and memory recall problems, usually understood other's verbal communication and had falls and unsteadiness and used a walker. The Level of Care/Assistance Plan Form dated 7/29/11 recorded the resident independent for dressing, transfer, walking, continence and toileting, personal hygiene tasks, and the resident had difficulty with recall requiring staff monitoring 1-2 times per shift. The Negotiated Services Agreement (NSA) dated 7/29/11 recorded staff provided the resident's fall prevention and pendant alarm, administered medications, managed the resident's diabetes, provided education, bathing, provided cues and reminders for activities and meals, provided personal laundry service, daily bed making, weekly cleaning and linens and social transportation. The Assisted Living Health Care Service Plan (care plan) dated 7/18/11 directed staff to cue the resident for meals and activities, do weekly laundry, provide bathing assistance weekly and monitor the resident every 1-2 hours because the resident was a fall risk.

The Fall Risk Assessment dated 7/29/11 recorded the resident's score was 18, and a total score of 10 or above represented high risk. The resident's Fall Risk Assessment score dated 7/31/11 was 18, on 8/2/11, the resident's fall risk score was 22, on 8/4/11 the score was 22 and on 8/5/11 the score was 22.

The physician's progress note dated 8/1/11 recorded the resident appeared to have difficulty with use of his/her walker, and the resident stayed on the assisted living unit on a temporary basis pending what would be a safer placement on the skilled unit when a bed was available.

The fall report dated 7/29/11 at 8:05 P.M.

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recorded staff found the resident on the floor next to his/her bed and denied hitting his/her head. Staff did not note any injury. The fall follow-up dated 8/8/11 (10 days after the fall) documented the resident returned to the facility that day (admitted), and staff should check the resident at least 1-2 hours when awake, and staff reminded the resident to call for assistance before getting up. (The 1-2 hour monitoring was already in place on the 7/18/11 care plan.)

The fall report dated 7/31/11 at 8:42 P.M. recorded the resident called for assistance, and when staff arrived the resident was found on the floor in the bathroom with his/her top half of body on the shower floor and the bottom half of body on the bathroom floor with the resident's head under the wooden bench board, and the resident denied hitting his/her head. Staff identified a 3 inch abrasion on the resident's right lower rib cage, and assisted the resident into bed. The resident then screamed in pain and complained of pain when staff did Range of Motion (ROM) on the resident's right leg. The fall follow-up dated 8/9/11 (9 days after the fall) recorded the resident complained of pain in "old fracture right hip." The fall follow-up recorded, "resident loses balance easily-reminded to call for all assistance, 18th fall since January, 2011. Resident checked every 1-2 hours-needs frequent monitoring and cueing." (The 1-2 hour monitoring was already in place on the 7/18/11 care plan, and the reminding and cueing was in place since the 7/29/11 fall.)

The nurses note dated 7/31/11 documented the resident fell again at 9:35 P.M. and staff sent the resident to the hospital's Emergency Room (ER).

The hospital chest x-ray report dated 8/1/11 recorded, "Right rib series with chest x-ray. Right

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S3155	Continued From page 7 rib injury and pain ...There is a non-acute fracture of the left 8th rib. There is an old fracture of what is likely the lateral aspect of the right 9th rib. No acute displaced rib fracture is identified." (A non-acute fracture is either one that occurs over time with repeated stress or impact of the area, or a chronically non-healing fracture.) The fall report dated 8/2/11 at 8:00 P.M. recorded staff found the resident on the floor and the resident complained of right rib pain from the previous fall and when staff assisted the resident to walk to the bathroom the resident complained of right hip pain as, "bone on bone". Staff assisted the resident to bed, called 911 and sent the resident to the hospital's ER. The fall follow-up dated 8/10/11 (8 days after the resident's fall) recorded staff sent the resident to the hospital, it was the resident's 3rd fall in 4 days, and the resident continued to be unaware of his/her falls. (No new fall prevention interventions were put in place.) The hospital right hip x-ray dated 8/2/11 recorded the resident had a right hip fracture repair, and no current fracture. The nurse's note dated 8/3/11 at 1:00 A.M. recorded the resident returned to the assisted living unit. Review of the nurse's note dated 8/4/11 at 4:00 P.M. revealed staff found the resident on the floor and the resident stated he/she did not fall. Facility staff did not do a fall report and did not initiate an investigation or any fall interventions after this fall. The fall report dated 8/5/11 at 1:00 P.M. recorded staff found the resident on the floor and lay on his/her back, and the resident did not know what	S3155		

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happened. Staff noted an abrasion on the resident's mid back. Staff also noted the resident denied hitting his/her head but was very confused. The fall follow-up dated 8/10/11 (5 days after the fall) directed staff to continue to check the resident every 1-2 hours during the day and every 2 hours at night, the resident was unstable and was waiting for a bed on the facility's skilled unit. (The 1-2 hour monitoring was already in place on the 7/18/11 care plan.)

The fall report dated 8/5/11 at 6:00 P.M. recorded staff witnessed the resident as he/she fell backward in the bathroom and sat on the floor. The fall follow-up dated 8/10/11 (5 days after the resident's fall) directed staff to continue to monitor every 1-2 hours related to increased falls, the resident needed continuous cueing, the resident's dementia was increasing and did not remember cues/reminders to call for assistance, and the resident was on hold for a bed on the facility's skilled unit related to increased falls. (The 1-2 hour monitoring was already in place on the 7/18/11 care plan, the reminding and cueing was in place since the 7/29/11 fall.)

Review of the nurse's note dated 8/6/11 at 7:00 A.M. recorded staff found the resident on the floor next to his/her bed and stated he/she did not fall. Facility staff did not do a fall report and did not initiate an investigation or any fall interventions after this fall.

The fall report dated 8/6/11 at 10:30 A.M. recorded staff found the resident sitting on the floor with his/her knees bent up, and the resident was very confused. The fall follow-up dated 8/10/11 (4 days after the fall) recorded the resident was not aware when he/she fell, had poor safety techniques, it was the resident's 22nd

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fall in 2011, and the 6th fall since the resident re-admitted to the assisted living unit, and the resident was on the waiting list for a bed on the skilled nursing unit. (No fall prevention interventions were put in place. The date on the follow-up, 8/10/11 (4 days after the fall, and the resident had already been injured during this fall, admitted to the hospital and then re-admitted to the skilled nursing facility.)

The nurse's note dated 8/6/11 at 11:30 A.M. recorded the resident was very lethargic and responding briefly to stimuli, and staff sent the resident to the hospital's ER.

The hospital's ER note dated 8/6/11 recorded the resident admitted to the hospital's Intensive Care Unit (ICU) with a cerebral hemorrhage.

Following the resident's hospital stay, the resident admitted to the facility's skilled nursing unit on 8/8/11 with a diagnosis of subarachnoid hemorrhage, (bleeding in the area between the brain and the thin tissues that cover the brain.) The hospital discharge summary dated 8/8/11 recorded, "Acute mental status change, secondary to left frontal subarachnoid hemorrhage, likely secondary to recurrent falling."

The Admission Nursing Assessment dated 8/8/11 recorded the resident had pale skin and numerous bruises on the left and right upper buttocks and back of waist, the left upper arm and both forearms, knees and back of left thigh.

The admission Interdisciplinary (IDT) note dated 8/8/11 at 11:15 P.M. recorded the resident admitted to the facility from the hospital for aftercare of subarachnoid hemorrhage, and had recently returned to his/her Assisted Lining (AL)

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apartment, where he/she had frequent falls, admitted to the hospital on 8/6/11 with a change in mental status and confusion, and the resident was "very unsteady" on his/her feet. The IDT note further described the resident's bruises as 2 bruises on the back rib area, a large bruise on his/her her right mid-back, a medium-large bruise on the right back of the thigh on posterior aspect, a small bruise on the left medial knee, and an old light green bruise to back of his/her her head as well as a red mark (old scar) on the left mid back, slight redness on the left anterior hip area, and a large bump on the left forearm.

During an interview on 3/14/12 at 8:02 A.M., administrative nursing staff B stated the resident's 8/4/11 and 8/6/11 falls recorded in the nurse's notes were usually considered a fall because the resident was found by the staff on the floor, and he/she did not know why staff did not initiate a fall report and investigation. Administrative nursing staff B stated he/she tried to implement a new intervention each time to prevent falls after the resident fell. One intervention they implemented was to check on the resident every hour, but they did not document that and it was not assigned to a staff member. Administrative staff B stated he/she thought the resident fell on purpose, and it was a behavior, that it was hard to come up with interventions to prevent the resident's falls, and "there was nothing more to do." Staff B further stated he/she identified the resident needed more supervision and that was why the resident waited for a bed on the skilled nursing unit, and thought he/she offered the resident's family the option to move the resident to another facility with a skilled nursing unit instead of waiting, but did not document that.

The facility provided the policy entitled Falls dated

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S3155	Continued From page 11 12/1/96 which directed residents would be identified for risk of falls and interventions implemented to reduce risk. Resident's high-risk status would be documented on the temporary and/or overall plan of care reflecting appropriate interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status. The facility failed to implement effective interventions and failed to provide adequate supervision for this dependent resident with a history of falls, injuries and hospitalizations from falls. - Resident #2's Physician Order Sheet (POS) dated 11/11 listed diagnoses that included paralysis agitans, injury to spine and spinal cord birth trauma, fall, malaise and fatigue, difficulty walking, muscle weakness, palliative care, contact dermatitis, eczema, aftercare follow surgery musculoskeletal system, urinary tract infection, anemia, pneumonia, post traumatic wound infection, hypertension, hypertrophy prostate without urinary obstruction and hypoosmolality and/or hyponatremia. The Functional Capacity Screen dated 11/18/11 recorded the resident required physical assistance with bathing, dressing, the facility managed medications and treatments, experienced impaired cognition, the resident had short term memory loss, memory/recall, impaired decision making, had falls and unsteadiness and used a walker. The Negotiated Services Agreement (NSA) dated 11/18/11 recorded staff provided the resident's fall prevention and pendant alarm, medications, medication management and treatments, provided education, bathing, provided cues and reminders for activities and meals, provided personal	S3155		

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laundry service, daily bed making, weekly cleaning and linens and social transportation. Noted, "Assistance related to safety issues-Parkinson's disease." The Assisted Living Health Care Service Plan (care plan) dated 11/18/11 directed, cue for meals and activities, daily bed making, weekly housekeeping with daily trash pickup, weekly laundry, hang clothes for resident, assist with dressing daily and undressing related to falls and Parkinson's disease, assist with bathing related to safety for falls and Parkinson's disease, provide social transportation as needed.

Review of the resident's medical record revealed the resident resided on the assisted living unit from 11/18/11 through 2/2/12.

Review of the resident's medical record revealed that during December 2011 and January 2012 the resident had 31 falls.

The fall report dated 12/1/11 at 8:00 P.M. recorded staff found the resident on the floor in front of recliner. The fall follow-up dated 12/5/11 (4 days after the fall), directed no change in care needed, staff did frequent checks, it was the resident's 7th fall, the resident got frequent skin tears, staff should constantly cue the resident to call staff for assistance, the resident was being treated for a toe wound, and the resident's family member was trying to set up an appointment for the resident to see a Neurologist.

The fall report dated 12/2/11 at 1:20 P.M. recorded staff found the resident on the floor next to his/her bed. The fall follow-up directed no change in care needed, the resident needed to wait for staff assistance and was non-compliant, the resident's Parkinson's disease worsened,

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S3155	Continued From page 13 staff should remind the resident to call for assistance, staff should keep the walker at the resident's side, the resident had skin tears and a toe wound which were being treated and the family tried to set up a Neurologist appointment. The fall report dated 12/3/11 at 7:15 15 P.M. recorded staff found the resident on the floor next to his/her dining table. The fall follow-up dated 12/6/11 (3 days after the fall), directed no change in care needed, the resident needed frequent checks, every 1-2 hours when awake, needed constant reminders to use his/her walker and to wait for staff assistance for safety, it was the 10th incident, 6th fall in the past 3 months, the resident received treatment on his/her toe wound and would need new shoes after healed and the facility was waiting for the family to set up appointments. The fall report dated 12/5/11 at 6:15 P.M. recorded staff found the resident kneeling in front of his/her recliner. The fall follow-up dated 12/6/11 directed no change in care needed, continue to cue the resident on asking for assistance, the resident was checked approximately every 1-2 hours for safety, staff should continue to cue the resident to ask for assistance, it was the 11th incident in 2011, the resident's family looked at possible furniture changes because the resident's recliner was too low for the resident. The fall report dated 12/6/11 at 4:40 P.M. recorded staff found the resident on the floor. The fall follow-up dated 12/8/11 (2 days after the fall), directed no change in care needed, the resident required constant cues and reminders for safety, and refused to give up his/her independence, it was the 12th incident, non-injury, the resident	S3155		

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bruised easily and had frequent skin tears. Some skin tears were not related to falls, and staff should continue to cue and remind the resident, the facility waited for the resident's toe wound to heal and for the neurology appointment and the resident's physician followed weekly regarding the resident's falls.

The fall report dated 12/6/11 at 7:04 P.M. recorded staff found the resident on the floor at the foot of his/her bed. The fall follow-up dated 12/8/11 (2 days after the fall), directed no change in care needed, staff continue to check the resident every 1-2 hours when awake, cue and remind the resident regarding safety, it was the resident's 14th incident since May, no new bruising or skin tears in the past 3 falls, the facility waited for the follow up appointment with Neurologist and staff looked at furniture placement and furniture changes for the resident.

The fall report dated 12/8/11 at 6:24 P.M. recorded a family member witnessed the resident tried to sit in his/her recliner and fell to the floor. The fall follow-up dated 12/10/11 (2 days after the fall), directed no change care needed, staff should continue to check the resident every 1-2 hours and as needed, advised the resident not to use the recliner and the resident's family looked into furniture options, it was the 14th incident, and the past 3 falls in the previous 8 days were related to the resident's recliner and the resident lost his/her balance when he/she attempted to sit in the recliner because it was too low.

The fall report dated 12/8/11 at 7:08 P.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 12/10/11 directed no change in level of care, staff to provide frequent reminders and checks, it was

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the 15th fall in 2011, the resident had a fall 35 minutes previously, the resident was non-compliant with calling for assistance, and staff reminded the resident not to use his/her recliner again.

The fall report dated 12/14/11 at 8:45 P.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 12/15/11 directed no change in care needed, 16th fall in the past 30 days, the resident had increased issues with mobility related to Parkinson's disease, staff suggested to the family to hire private duty caregivers for the resident, staff suggested to the resident's family to get a new chair (chair lift) for the resident, and the resident was a good candidate to move to the skilled nursing unit.

The fall report dated 12/21/11 at 3:00 A.M. recorded staff found the resident on the floor in front of the chair at the foot of the bed; the resident slid out of the chair. The fall follow-up dated 12/29/11 (8 days after the fall), directed the resident needed a change in his/her care, staff discussed private duty caregivers with the resident's family and they would provide care for 2 hours in the morning and 2 hours in the evening, it was the resident's 17th fall in 2011, and the family would provide a new chair related to resident fall issues from the chair that was too low, and the resident had unsafe walker practice.

The fall report dated 12/22/11 at 4:00 P.M. recorded staff found the resident at the foot of his/her bed. The fall follow-up dated 12/29/11 directed no change in care needed, private duty caregivers would assist with care, Activities of Daily Living (ADLs) and bathing already in place in the level of care for assistance, it was the

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S3155	Continued From page 16 resident ' s 20th fall, and the 4th fall that day, the resident had a new recliner but was not able to figure out how to use it, and staff should check the resident every 1-2 hours. (The facility lacked fall reports and investigations for the other 2 falls reported for 12/29/11.) The fall report dated 12/22/11 at 8:00 P.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 12/29/11 (7 days after the fall), directed the resident needed a change in his/her care, the family was interviewing private duty caregivers to provide care 4 hours per day, staff should continue to assist the resident with ADLs, staff should check the resident every 1-2 hours, the family would purchase a new chair for the resident's living room and the family inquired about moving the resident to the skilled nursing unit. The fall report dated 12/26/11 at 4:05 P.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 1/2/12 (7 days after the fall), directed no change of care needed, check every 1-2 hours when no private duty caregivers or family with the resident, the resident was not safe to use his/her walker and had poor safety and increased fall risk. The fall report dated 12/26/11 at 7:00 P.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 1/3/12 (8 days after the fall), directed no change of care needed, continue to check the resident every 1-2 hours when no family or private duty caregivers were present and the resident had steady physical and mental decline and poor safety awareness.	S3155		

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S3155	Continued From page 17 The fall report dated 12/28/11 at 4:13 P.M. recorded staff found the resident on the floor next to his/her overturned wheelchair. The fall follow-up dated 1/3/12 (7 days after the fall), directed no change of care needed, private duty caregivers assisted the resident 4 hours per day, the family visited, staff did hourly checks when they were not present, it was the resident's 22nd fall (11th this month), the resident had poor safety and did not remember to lock the wheelchair brakes before getting out of the chair, the resident was unable to use his/her walker at that time, and the family would like a bed in the skilled nursing unit for the resident when a bed was available. The fall report dated 12/29/11 at 12:05 A.M. recorded staff found the resident on the floor half under his/her desk and the resident rubbed his/her left arm but denied pain. The fall follow-up 1/5/12 (7 days after the fall), directed no change of care needed, staff should continue hourly checks when the private duty caregivers were not present, it was the resident's 24th fall in 2011 (18th this month), and the family wanted a skilled nursing unit bed for the resident when available. The fall report dated 12/29/11 at 6:48 A.M. recorded staff found the resident on the floor in front of his/her swivel chair. The fall follow-up dated 12/29/11 directed the resident needed a change of his/her care, the family looked into private duty caregivers that were not set up yet, staff should check the resident every 1-2 hours and as needed, it was the resident's 18th fall, the family was purchasing a new recliner and removing the swivel chair, and the facility was waiting for therapy to start. (This was the resident's 2nd fall on this date.)	S3155		

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S3155	Continued From page 18 The fall report dated 12/29/11 at 3:30 P.M. recorded staff found the resident on the floor by his/her recliner. The fall follow-up dated 1/5/12 (7 days after the fall), directed staff continue hourly checks when no private duty caregiver was present, have the resident only use his/her wheelchair rather than his/her walker, it was the resident's 25th fall and the 19th this month, and the family wanted a skilled nursing unit bed for the resident. (This was the resident's 3rd fall on this date.) The fall report dated 12/29/11 at 4:00 P.M. recorded staff found the resident on the floor in his/her living room. The fall follow-up dated 12/30/11 directed, no changed of care needed, private duty caregivers were with the resident 4 hours per day, the resident used his/her wheelchair for transport and remind the resident to ask for assistance. (This was the resident's 4th fall on this date.) The fall report dated 1/2/12 at 5:15 A.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 1/9/12 (7 days after the fall), directed the level of care increased, the resident had private duty caregivers 4 hours per day and received family assistance, staff should check the resident every hour when no caregiver was present, the resident had multiple skin tears from the last fall, and the family wanted a skilled nursing unit bed for the resident. The fall report dated 1/2/12 at 4:15 P.M. recorded staff found the resident on the floor in front of his/her recliner. The fall follow-up dated 1/9/12 (7 days after the fall), directed staff continue hourly checks, use only wheelchair for mobility, try to keep the resident in view or with staff if needed,	S3155		

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S3155	Continued From page 19 and the family requested the resident moved to the skilled nursing unit. The fall report dated 1/5/12 at 11:30 A.M. recorded staff found the resident on the floor at the foot of the bed. The fall follow-up dated 1/10/12 directed continue private duty caregivers and staff should check the resident hourly, and the family requested the resident be moved to the skilled nursing unit. The fall report dated 1/6/12 at 4:30 P.M. recorded staff witnessed the resident fell while ambulating behind walker and the walker grips were loose. The fall follow-up dated 1/10/12 (4 days after the fall), directed private duty caregivers 4 hours per day, continue hourly checks, and the family waited for the resident to be moved to the skilled nursing unit. The fall report dated 1/10/12 at 7:00 A.M. recorded staff found the resident on the floor at the foot of the bed. The fall follow-up dated 1/12/12 directed private duty caregivers for 2 hours in the A.M., and 2 hours in the evening, the resident required 1-2 staff for transfers related to safety, staff should continue hourly checks and keep the resident in staff's view when no caregivers were present. The fall report dated 1/12/12 at 12:15 A.M. recorded staff found the resident on the floor of his/her kitchen in front of an armchair. The fall follow-up dated 1/13/12 directed continue to have private duty caregivers 4 hours per day, staff should check the resident hourly or keep him/her in view of the staff, 1-2 staff needed for all transfers, the resident had multiple old and new skin tears from falls, and the family waited for the resident to be moved to the skilled nursing unit.	S3155		

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S3155	Continued From page 20 The fall report dated 1/12/11 at 11:03 P.M. recorded staff found the resident on the floor facing his/her recliner. The fall follow-up dated 1/16/12 (4 days after the fall), directed private duty caregivers 4 hours per day, and staff should continue frequent hourly checks, and the family waited for the resident to be moved to the skilled nursing unit. The fall report dated 1/13/12 at 4:10 P.M. recorded staff found the resident on the floor next to his/her bathroom door and the resident complained of left leg pain. The fall follow-up dated 1/16/12 (3 days after the fall), directed no change of care needed, continue private duty caregivers 4 hours per day, x-ray ordered for left ankle and negative for fracture, and the family waited for the resident to be moved to the skilled nursing unit. The fall report dated 1/17/12 at 2:00 A.M. recorded staff found the resident on the floor at the foot of his/her bed, and the resident complained of pain in his/her right foot. The fall follow-up dated 1/20/12 (3 days after the fall), directed no change of care needed, 9th fall in 2012, family considered 24 hour private duty caregivers and met with hospice providers, the resident had old skin tears from previous falls, and staff should continue to monitor the resident. The fall report dated 1/18/12 at 4:30 P.M. recorded staff found the resident on the floor beside his/her recliner. The fall follow-up dated 1/23/12 (5 days after the fall), directed no change of care needed, hospice and 24 hour caregivers pending family decision, 10th incident, the resident had a hematoma on his/her left hand, and the family waited for the resident to be	S3155		

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S3155	Continued From page 21 moved to the skilled nursing unit. The fall report dated 1/19/12 at 4:10 A.M. recorded staff found the resident on the floor next to his/her bed. The fall follow-up dated 1/24/12 (5 days after the fall), directed no change in care needed, 24 hour private duty caregivers to start on 1/20/12, it was the resident's 12th incident, the resident had new skin tears to his/her right elbow, the resident's old skin tears and bruises were healing, and the family waited for the resident to be moved to the skilled nursing unit. The fall report dated 1/19/12 at 3:50 P.M. recorded staff found the resident on the floor by his/her desk. The fall follow-up dated 1/23/12 (4 days after the fall), directed no change of care needed, 24 hour private duty caregivers start 1/20/12 at 7:00 A.M., the resident had a skin tear on his/her right thumb, the resident's old skin tears were healing, the resident hit his/her head during the fall and staff initiated neurology checks, staff should continue to monitor the resident, and the family waited for the resident to be moved to the skilled nursing unit. Observation on the skilled nursing unit on 3/8/12 at 4:34 P.M. revealed the resident in his/her wheelchair in the living room common area of the unit and bent over in the wheelchair with his/her feet on the floor and reached down and tried to place the television remote control on the wheelchair foot rest. At 4:37 P.M., staff in the area asked the resident to sit back in the wheelchair and the resident grabbed the staff's hands. At 4:49 P.M., the resident sat in his/her wheelchair, the left foot on the right footrest, and the right foot on the floor, and the resident self-propelled the wheelchair with his/her right hand. The resident continued to hold the remote	S3155		

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control in his/her left hand. At 4:52 P.M., the resident had both feet on the floor to the right side of the footrests, and was sharply turned in the wheelchair and almost sat sideways in the chair. When staff attempted to place the resident's feet back on the footrests the resident refused and attempted to hit the staff with the remote control.

During an interview on 3/14/12 at 8:02 A.M., administrative nursing staff B stated he/she recommended to the resident's family that the resident move to the skilled nursing unit because of increased supervision needs related to the resident's falls and there was not a bed available on the skilled nursing unit from 12/14/11 to 2/2/12. Administrative nursing staff B stated he/she thought he/she discussed the placement of the resident at another facility but was not sure and did not document that, and acknowledged he/she identified the resident needed more supervision than the assisted living unit could provide. In addition, administrative nursing staff B recommended the family purchase an electric lift recliner for the resident and did not perform an electric lift chair safety assessment for the resident, and the resident fell from the electric lift recliner chair, and acknowledged he/she documented the resident's confusion about how to safely use the electric lift chair controller. Administrative nursing staff B stated he/she tried to prevent falls for the resident, and acknowledged staff reminders to the resident and staff 1-2 hour checks on the resident were in place in the 11/18/11 care plan.

During an interview on 3/14/12 at 1:53 P.M., licensed staff I stated resident had many falls from his/her recliner on the assisted living unit and interventions included protecting the resident's skin with tubi-grips on his/her arms and

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S3155	Continued From page 23 legs, and staff encouraged him/her to call for assistance and made sure the resident's pendant (call light) was around the resident's neck. During an interview on 3/14/12 1:58 P.M., direct care staff J stated fall interventions for the resident included staff helped the resident to the dining room and occasionally helped him/her to the bathroom. During an interview on 3/14/12 at 2:01 P.M., direct care staff K stated the resident had falls when he/she was on the assisted living unit and interventions included staff checked the resident approximately every hour and made sure he/she had his/her call button if he/she needed to get up, but the resident did not use it. The facility provided the policy entitled Falls dated 12/1/96 which directed residents would be identified for risk of falls and interventions implemented to reduce risk. Resident's high-risk status would be documented on the temporary and/or overall plan of care reflecting appropriate interventions to minimize falls. Nursing staff would implement a system to alert staff to resident's high-risk status. The facility failed to implement effective interventions and failed to provide adequate supervision for this dependent resident with a known history of falls.	S3155		